

**TEXAS PULMONARY & CRITICAL  
CARE CONSULTANTS, P.A.**

*Pulmonary and Critical Care Specialists*

**SLEEP CONSULTANTS, INC.**

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***Comprehensive Care of Sleep Disorders: Diagnosis, Treatment, Follow-up, Education, Research***

**PATIENT SELF-REFERRAL**

Date: \_\_\_\_\_

Have you had prior sleep testing? – YES / NO If yes, when and where: \_\_\_\_\_

**Sleep-related diagnosis(es):** \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

**Patient Information:**

Last Name: \_\_\_\_\_ First Name/Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Sex: M F Marital Status: M S D W

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

*Place a check next to the best phone number to call, so we can contact you to make your appointment.*

Home Phone: \_\_\_\_\_  Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_  Other Phone: \_\_\_\_\_

Best time to call: \_\_\_\_\_

Employer: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

PCP Phone: \_\_\_\_\_ PCP Fax: \_\_\_\_\_

**Other physicians involved in your health care:** \_\_\_\_\_

**Primary Insurance Policy:**

Insurance Co. \_\_\_\_\_ ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Sex: M F

Claims Mailing Address \_\_\_\_\_

Phone No. \_\_\_\_\_

**Secondary Insurance Policy:**

Insurance Co. \_\_\_\_\_ ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Sex: M F

Claims Mailing Address \_\_\_\_\_

Phone No. \_\_\_\_\_